BPA Confidential Client Intake Form

State of Idaho Substance Use Disorder Treatment System

SECTION A: CLIENT INFORMATION

01.Legal Last Name:	02.Legal First Name:	03.Legal Middle Initial:	04.Suffix:
Doe	John	K	Mr
05.Alias/Nickname:		06.SS#:	07.DOB:
		555-55-5555	01/01/1995
08.Physical Address:			09.Apt/Trlr.#:
1000 South Blvd			
10.City:	11.State:	12.Zip Code:	13.Resident County:
Boise	ID	83702	01
14.Primary Phone #:	15.Marital Status:	16.Gender:	17.Ethnicity:
(208) 208-2008	Never Married (Single)	Male	Non Hispanic
18.Race:	19.Employment Status:	20.Head of Household:	21.Living Arrangement:
White	Student	No	Dependent Living
22. # of Children in Home:	23.Highest Grade Completed:	24.Income Source	25.Veteran Status:
2	11	None	No
26.Health Insurance:	27.If Medicaid Enter #:	28.Receiving WIC:	29.Payment Source:
Medicaid	444444444	No	Other Government
30.Open CPS Case:	31.Recent Domestic Violence:	32.Now Pregnant:	33.HIV Test:
No	No	No	No
34.IV-Usage:	35.Opiate Replacement Therapy:	36.Psych. Problems:	37.Client Type:
No	No	Yes	Youth Male
38.Client Target:	39.Admission Type:	40.Treatment Setting:	
Youth Juvenile Justice	Initial Admission	Freestanding	

41.Number of Prior Treatments:	42.Types of Treatments Attended:	43.# of Arrests in last 30 Days:
1	Outpatient	0

44. The number of times the client has attended a self-help program in the 30 days preceding the date of admission into treatment services. (includes attendance at AA, NA and other self-help/mutual support groups focused on recovery from substance abuse and dependence.

Mark Only One

a.No Attendance: ☐	b.(1-3) Times past Month: ☑	c.(4-7) Times past Month: ☐
d.(8-15) Times past Month: ☐	e.(16-30) Times Past Month: ☐	f.Not Collected: ☐
g. Unknown ☐	h.Attendance in past month but frequency unknown: ☐	

SECTION B: COLLATERAL CONTACT INFORMATION (Friends, Relatives used to follow up with clients post discharge)

01.Person's Name:	02.Relationship to Client:	03.Phone #:	04.Phone Type:
Martha Doe	Parent/Legal Guardian	(208) 555-5555	Cell
05.Person's Name:	06.Relationship to Client:	07.Phone #:	08.Phone Type:
John Doe Sr	Parent/Legal Guardian	(208) 555-5556	Home

SECTION C: SUBSTANCE USE (Prior to incarceration if applicable)

1.

Substance Use	Drug of Choice	Route of Administration	Age of First Use	Frequency of Use	Last Time Used
Primary	a. 0201	b. Oral	c. 12	d. 1-3 times past month	e. 06/01/2011
Secondary	f. 0401	g. Smoking	h. 12	i. 1-3 times past month	j. 06/01/2011
Tertiary	k.	l.	m.	n.	o.

SECTION D: REFERRAL TYPE

Criminal Justice Involvement

01.Adult Felon:	09.IDOC #:	17.Supervising County: Ada
02.Probation:	10.DHW Re-Entry:	18.Felony Drug Court:
03.Parole:	11.Currently Incarcerated:	19.DUI Court:
04.Supervised:	12.Transferred from TC or ND:	20.Juv. Drug Court:
05.Adult Misdemeanor:	13.Client Transferred from Rider	21.Mental Health Court:
06.Adolescent Misd: Yes	14.Client Topped out of Prison:	22.Juv. Mental Health Court:
07.Risk of Revocation:	15.Easter Seals/Goodwill:	23.Child Protection Drug Court:
08.ATR:	16.Idaho Code:	24.Referral Source: OCR

★ IF - ★ ATR CLIENT

SECTION E: REFERRAL INFORMATION (To include Probation, Parole Officers, Coordinators & IDOC Case Managers)

01. Printed Referral Name: PO Smith	02.Referral Title: Probation Officer	03.Referral Primary Phone #: (208) 555-5551	04.Ext:
05. Referral's Facility Name: Ada County Probation	06.City: Boise	07.State: ID	08.Zip: 83702
09. Judicial County: Ada	10.Email: PO@adaweb.net		

By placing my signature below I recommend this client to receive a substance use disorder assessment and necessary treatment to include recovery support services as part of his/her treatment plan.

11.Referral Authorizing Signature: PO Smith	12.Date: 7/4/11

SECTION F: REQUESTED SERVICES

★ Complete for ATR clients

01. Treatment Provider Name: Local Provider	02.Treatment Level of Care: Assessment	03.Site/City
04.Recovery Support Service Provider:	05.Service Type:	06.Site/City
07.Recovery Support Service Provider:	08.Service Type:	09.Site/City

10.List additional services requested here:

11.Restate Client's Full Legal Name: John Doe K	12.Intake Submission Date: 07-06-11

Financial Eligibility Form

We are required by law to keep information about you confidential. The information is not to be passed on to anyone else or to be used for any purpose other than to establish financial eligibility to access state funded services.

Client's Legal Name: John Doe	**Submission Type**
Client ID: 333333333	☑ Initial ☐ Financial Eligibility Update
Provider Name: Ada County Probation	**Date Completed** 07/06/2011
Client Social Security Number: 555-55-5555	

ELIGIBILITY DETERMINATION

All dollar amounts should be for the prior month.

1. Do You Have Insurance? To include Medicare, Veteran's benefits or other third party insurance.	No
2. Do You Have Medicaid? If yes, include Medicaid number here: 444444444	Yes
3. Number of People in Residence: Number of all individuals related to you by blood or marriage living on the property, including applicant, excluding those adults whose income is not considered.	4
4. Current Gross Income for Residence: When calculating the gross income of the family household, an adult residing with one or more parents, relatives or unrelated individuals shall constitute a separate family household as long as that adult is not claimed as a dependent of any parent, relative or unrelated individual for income tax purposes. Therefore, only that individual's income and the income of his or her spouse and dependent children (if residing in the same household) shall be considered when establishing the family unit for purposes of calculating his or her ability to pay consistent with IDAPA 16.07.01.	$1,200
5. Court-Ordered Obligations All Financial payments which have been ordered by a court that may include victim's restitution, courts costs and fees, fines, supervision costs, the drug court or mental health court fees, child support, and alimony.	$100
6. Dependent Support Amount paid for an individual that is dependent on his family's income for over fifty percent (50%) of his financial support; to include child support, elder care, and alimony.	$0
7. Child care payments necessary for employment	$300
8. Medical expenses Amount paid for insurance premiums, payments to doctors and hospitals, medication, physical therapy, and dental	$50

9. Transportation: Amount paid for car payments, gas, insurance, and public transportation.	
10. Extraordinary rehabilitative expenses Those payments incurred as a result of the disability needs of the person receiving services. They include monthly costs for items including, but not limited to, wheelchairs, adaptive equipment, medication, treatment, or therapy which were not included in the medical payments deduction and the annual estimate of the cost of services received.	
11. State and federal tax payments, including FICA	$200
12. Total Deductions: (Add lines 5 through 11)	$650
13. Income Amount Used to Determine Eligibility: (Subtract line 12 from line 4)	$550
14. Reimbursement Rate: (See reimbursement table)	0%

CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification and/or criminal or civil action. I understand that I may be asked to provide verification of my statements of income, statements of expenses and dependents.

Client Name and Signature: J Doe	Staff Signature: PO Smith
Date: 07/06/2011	Parent or Guardian Signature: Je Doe

GAIN-Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS 2.0.3

What is your name? a. John (First name) b. K (M.I.) c. Doe (Last name)

What is today's date? (MM/DD/YYYY) 01/01/1995

The following questions are about common psychological, behavioral, and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

IDScr

1. When was the last time that you had significant problems…
   a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? — (2)
   b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? — (1)
   c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? — (1)
   d. with becoming very distressed and upset when something reminded you of the past? — (1)
   e. with thinking about ending your life or committing suicide? — (2)

EDScr

2. When was the last time that you did the following things two or more times?
   a. Lied or conned to get things you wanted or to avoid having to do something? — (2)
   b. Had a hard time paying attention at school, work, or home? — (1)
   c. Had a hard time listening to instructions at school, work, or home? — (1)
   d. Were a bully or threatened other people? — (1)
   e. Started physical fights with other people? — (1)

SDScr

3. When was the last time that…
   a. you used alcohol or other drugs weekly or more often? — (2)
   b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs? — (2)
   c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? — (3)
   d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events? — (2)
   e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? — (0)

(Continued) After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

CVScr 4. When was the last time that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	3	2	(1)	0
b. took something from a store without paying for it?	3	2	1	(0)
c. sold, distributed, or helped to make illegal drugs?	3	2	1	(0)
d. drove a vehicle while under the influence of alcohol or illegal drugs?	3	2	1	(0)
e. purposely damaged or destroyed property that did not belong to you?	3	2	(1)	0

5. Do you have other significant psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below) ..... Yes (1) No 0

v1. ADHD

v2. _____

v3. _____

6. What is your gender? (If other, please describe below) ..... (1-Male) 2-Female 99-Other

v1. _____

7. How old are you today? |__|__| years

For Staff Use Only

8. Site ID: _____ Site Name v. _____
9. Staff ID: _____ Staff Name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1) Administered by staff 2) Administered by other 3) Self-administered
12. Number of 2s and 3s: IDSscr: 2 EDScr: 1 SDScr: 4 CVScr: 0 TDScr: 7
13. Referral: MH____ SA ____ ANG ____ Other ____ 14. Referral Code: _____
15. Referral comments:

v1. _____

v2. _____

v3. _____

Add # of 2s + 3s in each category

AUTHORIZATION FOR RELEASEOF INFORMATION
CRIMINAL JUSTICE REFERRAL

Legal Last Name	First Name	MI	Date of Birth
Doe	John	K	01/01/1995
Other Names Used			Case ID# 333333333

I, John Doe authorize (initial whichever parties apply):

JD Courts

_____ Idaho Dept of Correction

JD Idaho Department of Juvenile Corrections

_____ Prosecuting Attorney/s_____(Name of prosecuting attorney)

_____ Public Defender/other defense counsel_____(Name of criminal defense attorney)

JD County Probation

_____ Idaho Department of Health and Welfare

JD Parents (if a juvenile)_____ (Name)

JD Other (specify): Business Psychology Associates (BPA)

JD Other (specify): members of District SUD Comm

JD Other (specify): " " "

} LIST THOSE POs/OTHERS THAT WILL SEE CLIENT INFO

to release, use, receive, mutually exchange, communicate with and disclose to one another the following information:

JD my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

_____ _____

The purpose of the disclosure is to inform any person, entity, or agency listed above of my attendance and progress in treatment.

By placing my initials in the spaces below, I specifically understand that the following highly confidential information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization:

HIV/AIDS_____ Mental Health JD Alcohol/Drug JD Genetic_____ STD_____ TB _____

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose of the release of information. I am signing this authorization of my own free will. I understand that this authorization will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior and will also allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I further understand that some or all of this information will be discussed in open court, a public forum, where any person in the courtroom may hear the information. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

I understand that this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Although HIPPA requires that consents be revocable, 42 C.F.R. § 2.35 provides that if I am mandated into treatment through the criminal justice system or I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment. I also understand that if I do not comply with treatment, my non-compliance will be reported to the judge and the prosecuting attorney/deputy attorney. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

Compliance and Assurance Questionnaire

Please read and discuss all items and have client initial as they have read and understood each statement

1. I have clear understanding of my rights as a client and have been given the opportunity to discuss any of my concerns. JD
2. I understand if I decide not to sign, which is my right, I can be removed from treatment and will be reported to probation/parole, the judge and the prosecuting/deputy attorney. JD
3. I was given this release of information prior to beginning of treatment services. JD
4. I have been given the summary of the confidentiality laws. JD
5. I understand that this authorization ends on a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated to treatment. JD
6. If I am unable to read or comprehend this document, the release of information was read and explained in a manner, which I understand. JD
7. I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of information. JD
8. I was provided and have the right to ask for a copy of the signed release of information. JD
9. I understand that this authorization will expire one year from the signed date of release. JD

Full Legal Signature of Client or Authorized Personal Representative	Relationship to Client	Date
John Doe	Self	7-6-11
Full Legal Signature of Parent or Legal Guardian – Required if Client is under 16 years of age, but only after signed by Client.	**Relationship to Client**	**Date**
Martha Doe	mother	7-6-11
Name of Staff Person (print)	**Initiating Agency Name/Location**	**Date**

PROHIBITION ON REDISCLOSURE AND PROSECUTION: I understand that my alcohol and substance abuse treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, C.F.R. Part 2 and that recipients of this information may redisclose it only in connection with their official duties. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

JUVENILE JUSTICE SUBSTANCE USE DISORDER
AUTHORIZATION / DISCHARGE FORM

PART I: **Please indicate the requested action:** ⊙ Authorization ○ Re-authorization ○ Discharge

PART II: **DEMOGRAPHIC INFORMATION**

Authorized Start Date:	07/15/2011	Authorized End Date:	07/31/2011
District:	Four	County:	Ada
IJOS/CMS/Other Case #:	333333333	Date of Birth:	01/01/1995
Client's Full Legal Name:	John Doe		

PART III: **TREATMENT SERVICES**

✓	Level of Care	Provider Name / Site / City	Units/Days Approved
☑	Assessment (MI/SOC)	Assessments Inc / Ada County / Boise, ID	5
☐	Level I -- Outpatient	/ /	
☐	Level II -- Intensive Outpatient	/ /	
☐	Residential	/ /	
☐	Transitional Housing	/ /	
☐	Family Therapy	/ /	

PART IV: **RECOVERY SUPPORT SERVICES**

✓	Service	Provider Name / Site / City	Units/Days Approved
☐	Case Management	/ /	
☐	Drug Testing	/ /	
☐	Child Care	/ /	
☐	Life Skills	/ /	
☐	Transportation	/ /	
☐	Safe and Sober Housing	/ /	

PART V: **CLIENT DISCHARGE INFORMATION**

Please discharge client from all services effective on the following date: _____

○ Completed Successfully ○ Terminated Unsuccessfully ○ Other Disposition: _____

PART VI: **AUTHORIZING PARTY**

Print Name: PO Smith Title: Probation Officer

Signature: PO Smith Phone: (208) 555-5555 Date: 07/06/11

INSTRUCTIONS:

Authorization / Re-authorization: Part I: Check to indicate auth or re-auth form. Part II: Indicate beginning and ending date for allowable services; complete other demographic information. Part III and IV: Check type of service, include provider name and days or units approved. NOTE: For re-auth or auth of additional service for a client, complete the form for all services authorized in the treatment plan. Any services not included on the current form will be terminated for the client. Part VI: Provide contact information and sign form.

Client Discharge: Part I: Check to indicate discharge. Part II: Enter N/A for start and end dates; complete other demographic information. Part III and IV: Leave blank. Part V: Indicate date of effective discharge and outcome of treatment. Part VI: Provide contact information and sign form.